SAMHSA-HRSA
Center for Integrated Health Solutions

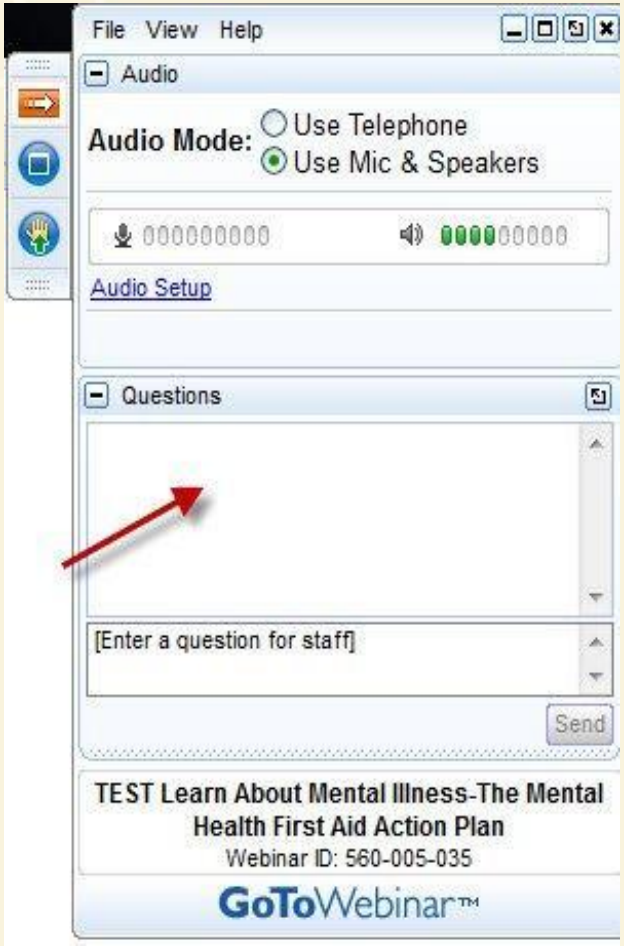
# Preparing for Bidirectional Integration: Lessons from the Field

June 14, 2012

2:00 – 3:30 pm ET

To submit a question, please type your questions into the question box and we will address your questions. **(right)**

If at any point during the webinar you experience technical difficulties, please call **Citrix tech support at 888.259.8414.**



SAMHSA-HRSA
Center for Integrated Health Solutions

# June 14, 2012 – IHP Learning Collaborative Project Management Model and Outcomes Achieved

MTM Services Faculty

# Integrated Health Providers Learning Collaborative:

**Powerful learning collaborative process that:**

1. Each of the 15 centers in the collaborative (8 MH/SU and 7 SU only) were at different stages of readiness to move to integrated healthcare delivery. All 15 had expressed the desire to move forward with integration efforts, however, each center has specific/somewhat unique challenges to overcome.
2. Therefore, the project management challenge was to develop a learning collaborative process that would facilitate each center starting the integration of healthcare process at different places and different focus areas… That would include:
   - Support for peer sharing of positive changes being made to move other cohort teams beyond the "realm of impossibility"…
   - Support the use of a CQI change process that can continue to provide implementable solutions into the future..

# Integrated Health Providers Learning Collaborative:

**Powerful learning collaborative process that:**

3. Provide clinical service delivery process changes that support enhanced consumer engagement in the areas of:
    1. Enhanced access to treatment timelines to reduce wait times and enhance consumer retention
    2. Integrated information gathering in the access to treatment process to reduce redundant information gathering from consumers
    3. Shift the clinical documentation process to a more person-centered collaborative documentation model which included providing consumer satisfaction survey support to measure the enhanced engagement (survey results will be presented based on 483 consumer responses).

# IHP Learning Collaborative Cohort

1. **APT Foundation**, New Haven, CT
2. **Brandywine Counseling and Community Services**, Wilmington, DE
3. **Centennial Mental Health Center**, Sterling, CO
4. **Community Health Resources**, Windsor, CT
5. **Community Services Northwest**, Vancouver, WA
6. **Connections** - Health·Wellness·Advocacy, Beachwood, OH
7. **Edgewater Systems**, Gary, IN
8. **Journey Mental Health Center**, Madison, WI
9. **Mecklenburg County Provider Services**, Charlotte, NC
10. **Mosaic Community Services**, Baltimore, MD
11. **New Age Services**, Chicago, IL
12. **Operation PAR**, Pinellas Park, FL
13. **Phoenix Houses of Mid-Atlantic**, Arlington, VA
14. **Seven  Counties Services**, Louisville, KY
15. **View Point Health**, Lawrenceville, GA

# Provider Learning Collaborative Goals

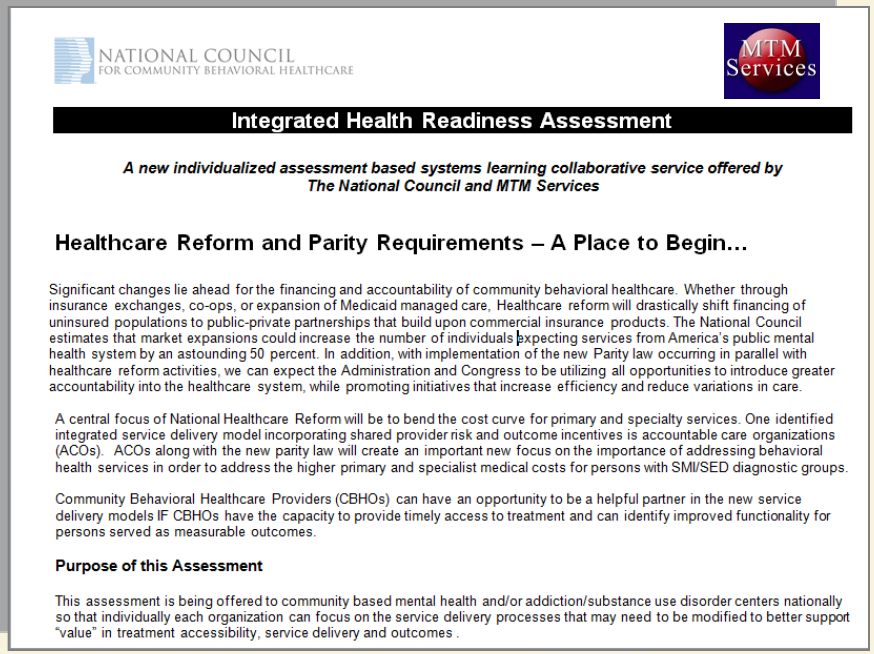
1. Provide basic information about the new integrated service delivery models being developed.
2. Provide an opportunity for each collaborative member to assess its readiness to participate
3. Provide technical assistance/support to collaborative members to facilitate their addressing the typical service delivery challenges that have historically created barriers to providing value enhanced services.
4. Develop a Rapid Cycle Change Plan for each member that will address specific change goals and objectives and a specific timeline to accomplish the changes needed.
5. Support a continuous quality improvement based learning experience for each member.
6. Provide an opportunity for collaborative members to share their attainment outcomes with other CBHOs

# Consultation and Technical Support Summary for Each Collaborative Member

1. **Healthcare Reform Readiness Assessment** was completed by each team to confirm the level of readiness to develop the capacity to provide primary care in each center. The MTM Faculty used each teams' information to design the goals/objectives in an individualized Rapid Cycle Change Plan for each team
2. **Monthly Internet based Rapid Cycle Change Plan** technical assistance support was provided to each team to support each center in the development and implementation of integrated primary and MH/SA service delivery models
3. **One (1) onsite consultation and training day** was provided by identified members of the MTM Faculty based on the focus of the technical assistance needed. The topic focus and agenda for each day was customized to the specific identified needs of each member
4. **A series of nine two hour monthly webinars** were provide so that all learning collaborative members and their respective change teams could receive support on areas of change or curriculum that was identified in the readiness assessment outcome.

# Integrated Health Readiness Assessment Completed in Summer 2011

- Evaluated 12 Domains:
  1. Access to Services
  2. Centralized Scheduling & Cancellation Protocols
  3. Key Performance Indicators & Rate Standards
  4. LOC Benefit Package Design & Caseload Management
  5. No Show/Cancellation Management
  6. Collaborative Documentation Process
  7. Outcome Assessment Capacity
  8. Internal UM
  9. Community Awareness, Branding & Market Share
  10. Revenue Management
  11. Measurement of KPI Capacity
  12. Change Management & Decision-Making Culture



NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

MTM Services

**Integrated Health Readiness Assessment**

***A new individualized assessment based systems learning collaborative service offered by The National Council and MTM Services***

**Healthcare Reform and Parity Requirements – A Place to Begin…**

Significant changes lie ahead for the financing and accountability of community behavioral healthcare. Whether through insurance exchanges, co-ops, or expansion of Medicaid managed care, Healthcare reform will drastically shift financing of uninsured populations to public-private partnerships that build upon commercial insurance products. The National Council estimates that market expansions could increase the number of individuals expecting services from America's public mental health system by an astounding 50 percent. In addition, with implementation of the new Parity law occurring in parallel with healthcare reform activities, we can expect the Administration and Congress to be utilizing all opportunities to introduce greater accountability into the healthcare system, while promoting initiatives that increase efficiency and reduce variations in care.

A central focus of National Healthcare Reform will be to bend the cost curve for primary and specialty services. One identified integrated service delivery model incorporating shared provider risk and outcome incentives is accountable care organizations (ACOs). ACOs along with the new parity law will create an important new focus on the importance of addressing behavioral health services in order to address the higher primary and specialist medical costs for persons with SMI/SED diagnostic groups.

Community Behavioral Healthcare Providers (CBHOs) can have an opportunity to be a helpful partner in the new service delivery models IF CBHOs have the capacity to provide timely access to treatment and can identify improved functionality for persons served as measurable outcomes.

**Purpose of this Assessment**

This assessment is being offered to community based mental health and/or addiction/substance use disorder centers nationally so that individually each organization can focus on the service delivery processes that may need to be modified to better support "value" in treatment accessibility, service delivery and outcomes .

# Readiness Assessment Aggregate Results

| MTM Services — Learning Collaborative Team: | APT Foundation | Brandywine Counseling | Centennial MHC | Community Health Resources | Community Services Northwest | Edgewater Systems | Mecklenburg County SASC | Mecklenburg County - Shelter | MHC of Dane County | Mosaic Community Services | New Age Services |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Average Rating:** | **2.1** | **1.9** | **1.9** | **2.0** | **1.8** | **2.3** | **1.8** | **1.9** | **1.9** | **2.1** | **1.6** |
| 1. Do any clinicians/direct care staff maintain their own individual schedules (in books or personal calendars)? | 1 | 1 | 3 | 2 | 3 | 1 | 3 | 1 | 1 | 3 | 1 |
| 2. Does the organization have a software based electronic scheduling capacity? | 1 | 3 | 3 | 2 | 3 | 3 | 3 | 2 | 3 | 2 | 1 |
| 3. Does the organization's front desk manage the schedule for ongoing appointments? | 3 | 1 | 1 | 2 | 3 | 2 | 2 | 1 | 1 | 2 | 1 |
| 4. Does the organization manage new requests for services though a centralized scheduling process? | 3 | 1 | 3 | 3 | 3 | 3 | 1 | 1 | 3 | 3 | 3 |
| 5. Does the organization's staff call clients prior to their scheduled appointments? | 1 | 1 | 1 | 1 | 3 | 3 | 2 | 1 | 3 | 3 | 1 |
| 6. Does the organization have an appointment back fill process for all client canceled appointments? | 1 | 1 | 1 | 1 | 1 | 3 | 1 | 1 | 1 | 1 | 1 |
| 7. Does the organization have a "Will Call" status/list for clients seeking appointments or for clinicians who want to work a client into their schedules? | 1 | 1 | 1 | 1 | 1 | 3 | 1 | 1 | 1 | 1 | 1 |
| 8. If the organization has community based staff, are their scheduled activities incorporated into the centralized scheduling process? | 2 | 1 | 3 | 1 | 1 | 3 | 2 | | 1 | 2 | 2 |
| 9. Does the organization have a "standing appointment" requirement for all clinical/direct care staff (i.e., staff provide centralized scheduler when they will take PTO, annual leave, meetings, etc.) | 1 | 2 | 2 | 2 | 1 | 3 | 1 | 1 | 1 | 2 | 1 |
| 10. Does the organization have a utilization management plan in place to ensure that they only schedule clients with appropriate clinicians on the appropriate funder panels? | 1 | 1 | 3 | 2 | 1 | 1 | 1 | 2 | 1 | 3 | 3 |
| 11. Does the organization have scheduling templates for each clinician/direct care staff that includes sufficient appointments per day to absorb each staff's no show/cancellation rate? | 1 | 1 | 1 | 2 | 3 | 3 | 1 | 2 | 1 | 3 | 1 |
| 12. Other information about clinician/direct care staff scheduling that will be helpful: | | | 1 | | 2 | | | | | | |

**Color Key:** Red (1) = High Concern/RCCP Focus  Yellow (2) = Consider Change Needs  Green (3) = No Change Recommended

# Integrated Health Readiness Assessment Results Based on a Three Point Scale (1 = High Concern, 2 = Concern, and 3 = Commendation)

- Identified specific level of concern in each of 12 domains for each of the 15 centers
- Provided each of the 15 centers an average readiness score
- Prioritized needs for each center
- Informed development of goals and recommendations for individualized Rapid Cycle Change Plans

| Learning Collaborative Team: | Average Rating: |
|---|---|
| APT Foundation | 2.1 |
| Brandywine Counseling | 1.9 |
| Centennial MHC | 1.9 |
| Community Health Resources | 2.0 |
| Community Services Northwest | 1.8 |
| Edgewater Systems | 2.3 |
| Mecklenburg County SASC | 1.8 |
| Mecklenburg County - Shelter | 1.9 |
| MHC of Dane County | 1.9 |
| Mosaic Community Services | 2.1 |
| New Age Services | 1.6 |
| Northeast Ohio Health Services | 1.9 |
| Operation PAR | 1.9 |
| Phoenix Houses | 1.8 |
| Seven Counties - MH Services | 1.5 |
| Seven Counties - Developmental Services | 1.3 |
| View Point Health | 1.7 |

# Rapid Cycle Change Goal Recommendations Based on Readiness Assessment Findings

| | Of 15 Centers |
|---|---|
| 1. Enhance Access to Treatment Timeliness | 9 |
| 2. Develop and implement Centralized Schedule Management including Will Call and Back Fill Support | 12 |
| 3. Develop and implement No Show/Cancellation Management including Scheduling Templates and Engagement Specialist | 11 |
| 4. Design and Implement re-engagement/transition procedures for current cases not actively in treatment. | 10 |
| 5. Provide Training and Implement Collaborative Concurrent Documentation | 10 |
| 6. Design and implement Levels of Care/Benefit Package Designs to support appropriate utilization levels. | 11 |
| 7. Develop and implement an enhanced Outcome Assessment Capacity (i.e., PHQ-9, DLA-20, etc.) | 12 |
| 8. Develop and implement integrated primary care services. | 13 |
| 9. Develop and implement Cost Based Key Performance Indicators (KPIs) | 8 |
| 10. Develop and implement Capacity to Measure KPIs to support coaching/mentoring activities by supervisors/managers | 9 |
| 11. Develop and implement payer mix enhancements including Third Party Payers | 13 |
| 12. Design and implement internal utilization management functions including Credentialing Support for Clinical Staff; Pre-Certs, authorizations and re-authorizations; and referrals to clinicians credentialed on the appropriate third party/ACO panels | 11 |
| 13. Develop and implement enhanced Revenue Cycle Management including co-pay collections and claim submission | 10 |
| 14. Develop and implement enhanced community awareness support including collaboration with medical providers | 11 |

# Rapid Cycle Change Plan Sample

**Version: November 15, 2011**

**Operation PAR**

**Access Redesign Initiative**

**Implementation Scope of Work and Timeline**

MTM Services | Design/Plan | Training | Pilot | Final Implementation

| | Scope of Work Tasks | 2011 Sep-11 | Oct-11 | Nov-11 | Dec-11 | 2011 Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Collaborative Documentation: Moving from post session documentation | | | | | | | | | | | | | | | | |
| A | Review Equipment Needs/Office Setup/Form Design/Training Needs | | | | | | | | | | | | | | | | |
| B | Measure the Current documentation reality for Staff | | | | | | | | | | | | | | | | |
| C | Create introduction script and Evaluation questions - Pilot Process to confirm any local issues | | | | | | | | | | | | | | | | |
| D | Next Steps | | | | | | | | | | | | | | | | |
| E | Team: Ted, Linda, Stephanie, Drew | | | | | | | | | | | | | | | | |
| Ev1 | Evaluation of Action Steps Implemented for Possible Redesign | | | | | | | | | | | | | | | | |
| 2 | Walk-In Models: Offering more expedient access to care which helps | | | | | | | | | | | | | | | | |
| A | Walk-in Model for the organization | | | | | | | | | | | | | | | | |
| B | Establish Customer Engagement Standards for care management, out-patient services and medical services? | | | | | | | | | | | | | | | | |
| C | Team: Wendy, Ken, Drew | | | | | | | | | | | | | | | | |
| Ev2 | Evaluation of Action Steps Implemented for Possible Redesign | | | | | | | | | | | | | | | | |
| 3 | No Show Management: Work through policy changes and counseling | | | | | | | | | | | | | | | | |
| A | Implement the new policy and procedure. | | | | | | | | | | | | | | | | |
| B | 48 Hour Reminder/Rebooking Calls | | | | | | | | | | | | | | | | |
| C | Team: Deanna, Ted, Clinical Supervisors Group | | | | | | | | | | | | | | | | |
| D | | | | | | | | | | | | | | | | | |

# Monthly Cohort Webinar Topics – Based on Readiness Assessment and Center Evaluations

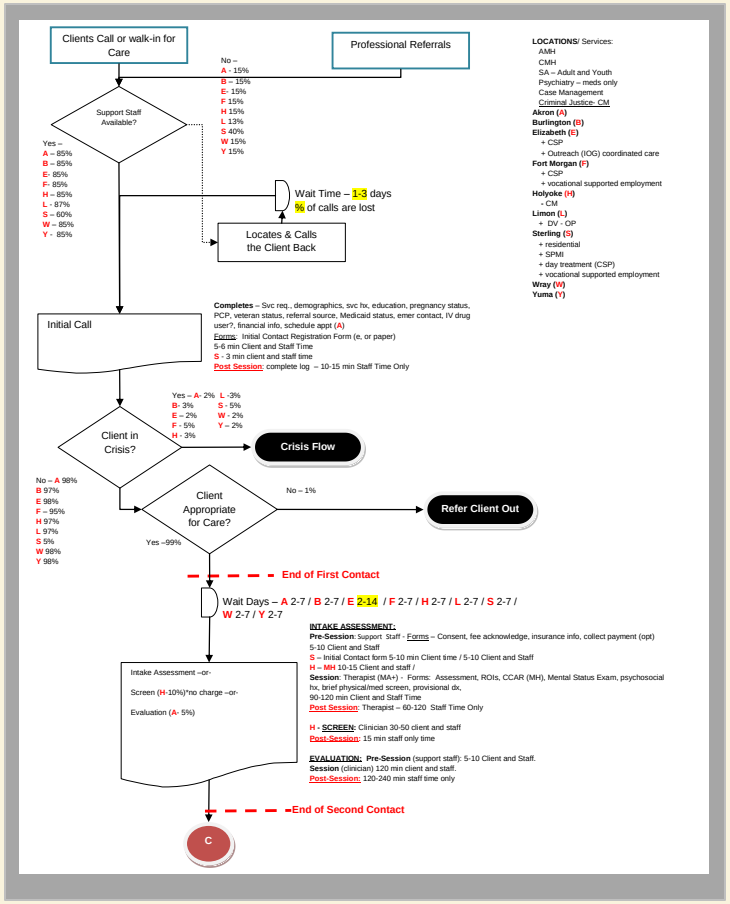
| Session Number | Two Hour Friday Webinar Dates | Topic Focus Areas |
|---|---|---|
| Session One | 7-22-11 | Orientation Learning Conference:<br>• Overview of Learning Community Activities Available<br>• How to perform a provider readiness assessment Using the Fourteen Area Reform Readiness Assessment - *Readiness Assessment*<br>• Ability to use rapid cycle change management model to support the goals and objectives needed to ensure implementation of needed changes |
| Session Two | 8-19-11 | Integrated Healthcare – How will it Look and How will We Get There?<br>• Analyze the medical specialty(s) capacity within the community and seek to integrate the identified medical service capacity(s) into the person-centered healthcare home or create person-centered referral pathways.<br>• Develop and implement employment and/or contracting protocols including algorithms to support integrated medical specialty(s) in the person-centered healthcare home |
| Session Three | 9-16-11 | Integrated access to treatment process flows and "Same Day/Open Access" to service models |
| Session Four | 10-14-11 | Centralized Scheduling, Scheduling Templates, Back Fill and Will Call Models and No Show Management Models including Person-Centered Engagement Strategies, Alternate Service Delivery Models and the Engagement Specialist Support Model |
| Session Five | 11-18-11 | Assessing current Caseload Management levels and designing and implementing Benefit Designs and Levels of Care as Both an Utilization Management and Engagement Tool |
| Session Six | 1-20-12 | Access Flow Outcomes, Increasing Evidenced Based Practices in the Medical Home and Payment Models in an Integrated Care Setting |
| Session Seven | 2-17-12 | Develop and implement employment and/or contracting protocols, Integrated Care Teams and Continuum of Collaborative Care |
| Session Eight | 3-16-12 | Medical Model Approach for BH Trained Staff, Motivational Interviewing and Electronic Health Records |
| Session Nine | 4-20-12 | Integrated Care Teams – Roles and Procedures and Shared Risk Bundled/Episodic Payment Models |
| Session Ten – Outcomes Learning Conferences | 5-4-12<br>5-11-12<br>5-18-12 | Case Studies - Providers that participated in the Learning Community will be asked to present case studies of their outcomes achieved, lessons learning and next steps they plan to take during the four half day Outcome Webinar Conferences |

# MTM Services Faculty and Focus Areas

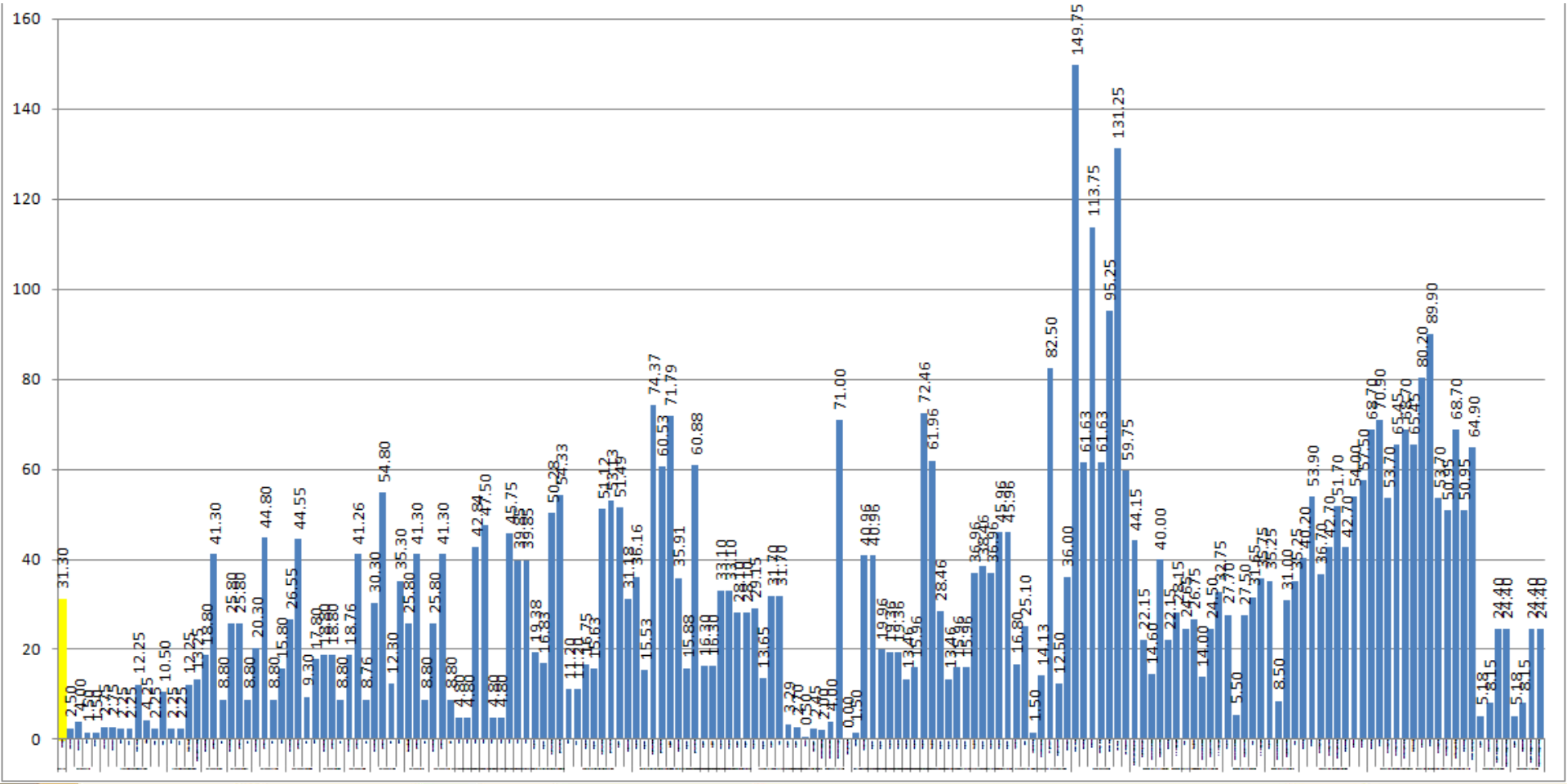
| Faculty Member | Consultation Experience | Focus Area(s) for This Initiative |
|---|---|---|
| **David Lloyd**, Founder MTM Services | • Senior Consultant for the National Council<br>• Author of: "How to Deliver Accountable Care" | • Learning Collaborative Project Management<br>• Integrated Health Management |
| **Scott Lloyd**, President MTM Services | • Lead Consultant for the National Council<br>• Author of: "Using Data to Drive Your Service Delivery Strategies" | • Access to Care Process Flow, Data Mapping, Costing and Rapid Cycle Change Support |
| **Michael Flora**, MBA, MA.Ed., LPCC, LSW | • Lead MTM Operations and Management Consultant<br>• Consultant for the National Council<br>• CEO of the Ben Gordon Center in DeKalb, IL | • Summary of Findings and Recommendations on Readiness Assessments and Rapid Cycle Change Support |
| **David Swann**, MA, LCAS, CCS, LPC, NCC | • Senior MTM Integrated Healthcare Consultant<br>• Consultant for the National Council<br>• CEO of a public Managed Care Entity in NC | • Access to Care Process Flow, Data Mapping, Costing<br>• Integrated Health Service Delivery Models |
| **Bill Schmelter**, Ph.D. | • Senior MTM Clinical Consultant<br>• Consultant for the National Council | • Integrated Clinical Documentation Support<br>• Consumer Engagement Strategies |
| **Noel Clark**, M.A. | • Lead MTM Access and Engagement Consultant<br>• Consultant for the National Council<br>• CEO of Carlsbad MH Center in Carlsbad, NM | • Open/Same Day Access to Care Models<br>• Benefit Designs/LOCs |
| **Joy Fruth**, MSW | • Lead MTM Lead Process Change Consultant<br>• Consultant for the National Council | • Access to Care Process Flow, Data Mapping, Costing and Rapid Cycle Change Support |
| **Katherine Hirsch**, MSW, LCSW | • Lead MTM Child/Adolescent Clinical Consultant<br>• Consultant for the National Council | • Collaborative Documentation Training Support |
| **Alison Pleasants**, Executive Administrative Support | • Lead Scheduler for Internet Meetings and Onsite Training | • Coordinate all Internet Session with Teams and Onsite Training Logistics |

# Gap Analysis- Completed Summer/Fall of 2011

- At each agency, Gap Analysis Teams (GATs) convened consisting of 2 direct service staff from each level of service along intake continuum
- Individual internet meetings scheduled with each GAT
- Measured First Client Contact, through completion of Treatment Plan
- Gap Analysis with 15 Centers resulted in 193 Individual Process Flows
- **Goal:** Identify Process Redundancy and Wait Times



# Access Process - Wait time by Organization and Division



# Intake Cost Analysis Example



| Demographic Information | | | | Practice/Engagement Information | | | | Financial Information | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Location | Division | State | Total Staff Time (Hrs) | Total Client Time without Wait-time (Hrs) | # of Intakes Completed Per Month | Total Wait-time (Days) | Cost for Intake Process | Revenue for Intake Process | Gain/Loss per Intake | Monthly Margin | Annual Margin |
| 1 | [redacted] | Adult MH | [redacted] | 3.58 | 2.14 | 19 | 19.383 | $242.44 | $109.00 | ($133.44) | ($2,535.31) | ($30,423.75) |
| 2 | | Child MH | | 4.43 | 2.70 | 11 | 16.8315 | $304.63 | $109.00 | ($195.63) | ($2,151.88) | ($25,822.50) |
| 3 | | Adult Psychiatric | | 4.76 | 3.16 | 0 | 50.283 | $444.25 | $109.00 | ($335.25) | $0.00 | $0.00 |
| 4 | | Child Psychiatric | | 5.94 | 4.03 | 0 | 54.3315 | $416.35 | $109.00 | ($307.35) | $0.00 | $0.00 |
| 5 | | Adult MH | | 4.17 | 2.72 | 55 | 23 | $286.81 | $109.00 | ($177.81) | ($9,779.69) | ($117,356.25) |
| 6 | | Child MH | | 4.68 | 2.82 | 29 | 16 | $323.38 | $109.00 | ($214.38) | ($6,216.88) | ($74,602.50) |
| 7 | | Adult SA | | 5.29 | 3.70 | 0 | 51 | $478.53 | $109.00 | ($369.53) | $0.00 | $0.00 |
| 8 | | Adolescent SA | | 5.27 | 3.33 | 0 | 31 | $424.28 | $109.00 | ($315.28) | $0.00 | $0.00 |
| 9 | | Adult Psychiatric | | 5.35 | 3.75 | 0 | 51 | $488.63 | $109.00 | ($379.63) | $0.00 | $0.00 |
| 10 | | Child Psychiatric | | 6.10 | 4.10 | 0 | 53 | $568.94 | $109.00 | ($459.94) | $0.00 | $0.00 |
| 13 | | Adult MH | | 3.50 | 2.01 | 85 | 36 | $236.56 | $109.00 | ($127.56) | ($10,842.81) | ($130,113.75) |
| 14 | | Child MH | | 4.47 | 2.61 | 17 | 16 | $307.75 | $109.00 | ($198.75) | ($3,378.75) | ($40,545.00) |
| 15 | | Adult SA | | 4.62 | 2.99 | 0 | 72 | $428.28 | $109.00 | ($319.28) | $0.00 | $0.00 |
| 16 | | Adolescent SA | | 7.22 | 4.68 | 3 | 36 | $570.53 | $109.00 | ($461.53) | ($1,384.59) | ($16,615.13) |
| 17 | | Adult Psychiatric | | 4.68 | 3.04 | 0 | 74 | $438.38 | $109.00 | ($329.38) | $0.00 | $0.00 |
| 18 | | Child Psychiatric | | 5.90 | 3.89 | 0 | 61 | $553.31 | $109.00 | ($444.31) | $0.00 | $0.00 |
| 19 | | Child MH | | 4.35 | 2.61 | 10 | 16 | $298.38 | $109.00 | ($189.38) | ($1,893.75) | ($22,725.00) |
| 20 | | Child Psychiatric | | 5.77 | 3.89 | 0 | 61 | $543.94 | $109.00 | ($434.94) | $0.00 | $0.00 |
| 21 | | Adult SA | | 6.72 | 3.85 | 0 | 16 | $612.03 | $109.00 | ($503.03) | $0.00 | $0.00 |
| 22 | | Adult SA | | 6.72 | 3.85 | 0 | 16 | $612.03 | $109.00 | ($503.03) | $0.00 | $0.00 |
| | | | Average | 5.08 | 3.24 | 28.63 | 36.02 | ($415.85) | ($109.00) | ($306.85) | ($4,772.96) | ($57,275.48) |

| | |
|---|---|
| Total Number of Intakes Per Month | 229 |
| Total Monthly Margin: | ($38,183.66) |
| Total Annual Margin: | ($458,203.88) |

# Initial Access Flow Cohort Outcomes

1. Measurement of current processes from first call for routine help to treatment plan completion
2. Measurement processes provided indicate that the cohort of 15 centers have 193 different flow processes
3. Number of staff hours needed range from .5 hours to 11.7 hours – Cohort average is 5 hours of staff time
4. Cost of processes range from $11 to $855 – Cohort average cost is $369
5. Total days wait to treatment range from less than one day to 150 calendar days – Cohort average wait time is 31.30 calendar days for all divisions/programs

# Access to Treatment National Best Practice Target Averages

1. Access to Treatment processes within each center:
   - Gold Standard – Standardized Process for the center
   - Silver Standard – No more than one per division
2. Number of staff hours needed from first call for help to treatment plan completion range from 2 hours to 2.5 hours which will require staff to use collaborative documentation process
   - Assessment process target is one hour using CSR support
3. Cost of processes range from $150 to $200
4. Total days wait to treatment for therapist/case manager is 8 calendar days or less and to MD/APRN is 10 total calendar days or less from Intake/Assessment

# Change Measurement



# Pilot / Implementation Phase for RCCP Efforts

| Integrated Health Learning Collaborative | # | | | |
|---|---|---|---|---|
| Total # of Organizations at Start | 15 | % | | |
| Total # of Organizations at the Finish | 15 | 100% | | |
| **Status of Change Strategy** | **Initially Selected** | **%** | **Piloted/Implemented** | **%** |
| Integrated Primary Care Services | 11 | 73% | 11 | 100% |
| Enhanced Access to Treatment Timeliness | 11 | 73% | 10 | 91% |
| Collaborative Documenatation | 9 | 60% | 8 | 89% |
| Centralized Schedule Management | 10 | 67% | 4 | 40% |
| Re-engagement/Transition Procedures | 8 | 53% | 3 | 38% |
| No Show/Cancellation Management | 9 | 60% | 3 | 33% |
| Levels of Care/Benefit Package Design | 9 | 60% | 3 | 33% |
| Enhanced Outcome Capacity | 7 | 47% | 2 | 29% |
| KPI Measurement - support coaching/mentoring | 6 | 40% | 2 | 33% |
| Cost Based Key Performance Indicators | 6 | 40% | 1 | 17% |
| Enhanced Community Awareness / Med Provider Collaboration | 8 | 53% | 1 | 13% |

# Integrated Care Outcomes for RCCP Efforts

| IHLPC Organization | First Quarter 2012 | Prior to First Quarter 2012 | Total Number Per Center |
|---|---|---|---|
| View Point Health | 1 | 1 | 2 |
| Seven Counties Services | 0 | 0 | 0 |
| Brandywine | 0 | Note: Developed onsite primary care | 1* |
| Community Services Northwest | 0 | 0 | 0 |
| Mosaic | 0 | 2 - Currently collaborate with 2 FQHCs, seeking a 3rd | 2 |
| Operation PAR | 0 | 0 | 0 |
| Centennial | 1 | 1 | 2 |
| New Age Services | 1 | 0 | 1 |
| Phoenix House | 0 | 0 | 0 |
| Mecklenburg County | 1 | 0 | 1 |
| Northeast Connections | 0 | Note: Working on providing PC onsite | 1* |
| APT | 0 | Note: Developed on site primary care | 1* |
| Community Health Resources | 0 | 0 | 0 |
| Edgewater Systems | 0 | 1 | 1 |
| MHC of Dane County (Journey MHC) | 1 | 0 | 1 |
| North East Ohio | Note: Letter of Intent submitted to State of Ohio for Medical Home. Submitted 3 year grant to support Integration of BH/PCP | 0 | 1* |
| TOTALS | 6 | 8 | 14 |

**Note*: Developed onsite primary care capacity or application for Medical Home status**

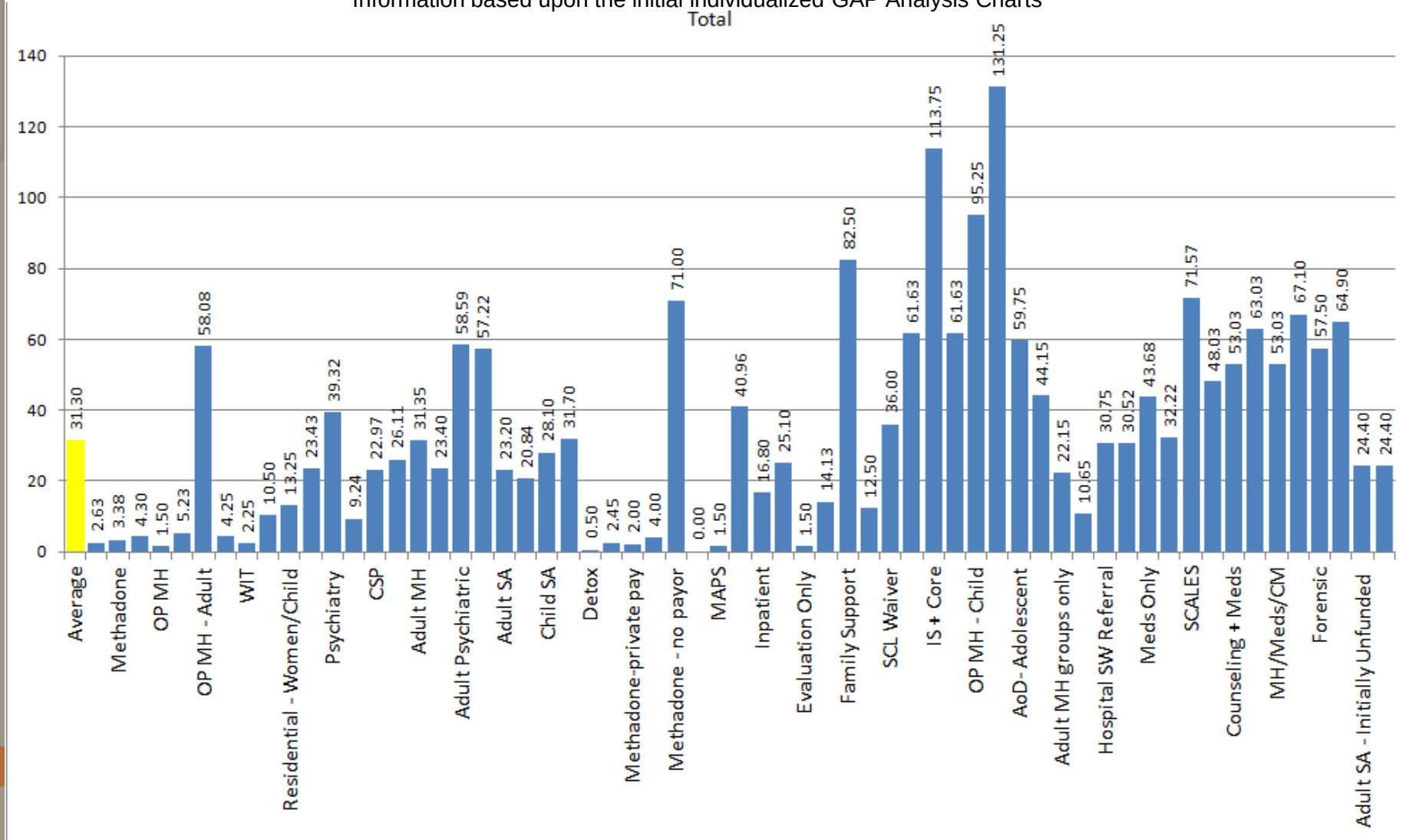
# Improved Timeliness of Access to Care

1. Multiple Teams reported a complete restructuring of Access/Intake Processes, removing redundancies and unnecessary steps resulting in cohort average reduction in calendar wait days to care from 25 days to 14 days.
2. Centralized Scheduling
   - implemented by 26% of Teams
   - Indicated by one Team as “Most Notable Achievement” for increasing productivity
3. Open Access
   - Piloted/Implemented by 46% of all Cohort
   - Open Access was highlighted by 5 Individual Centers as their “Most Notable Achievement”.

# Access to Treatment Process Flows – Measurement Process Summary

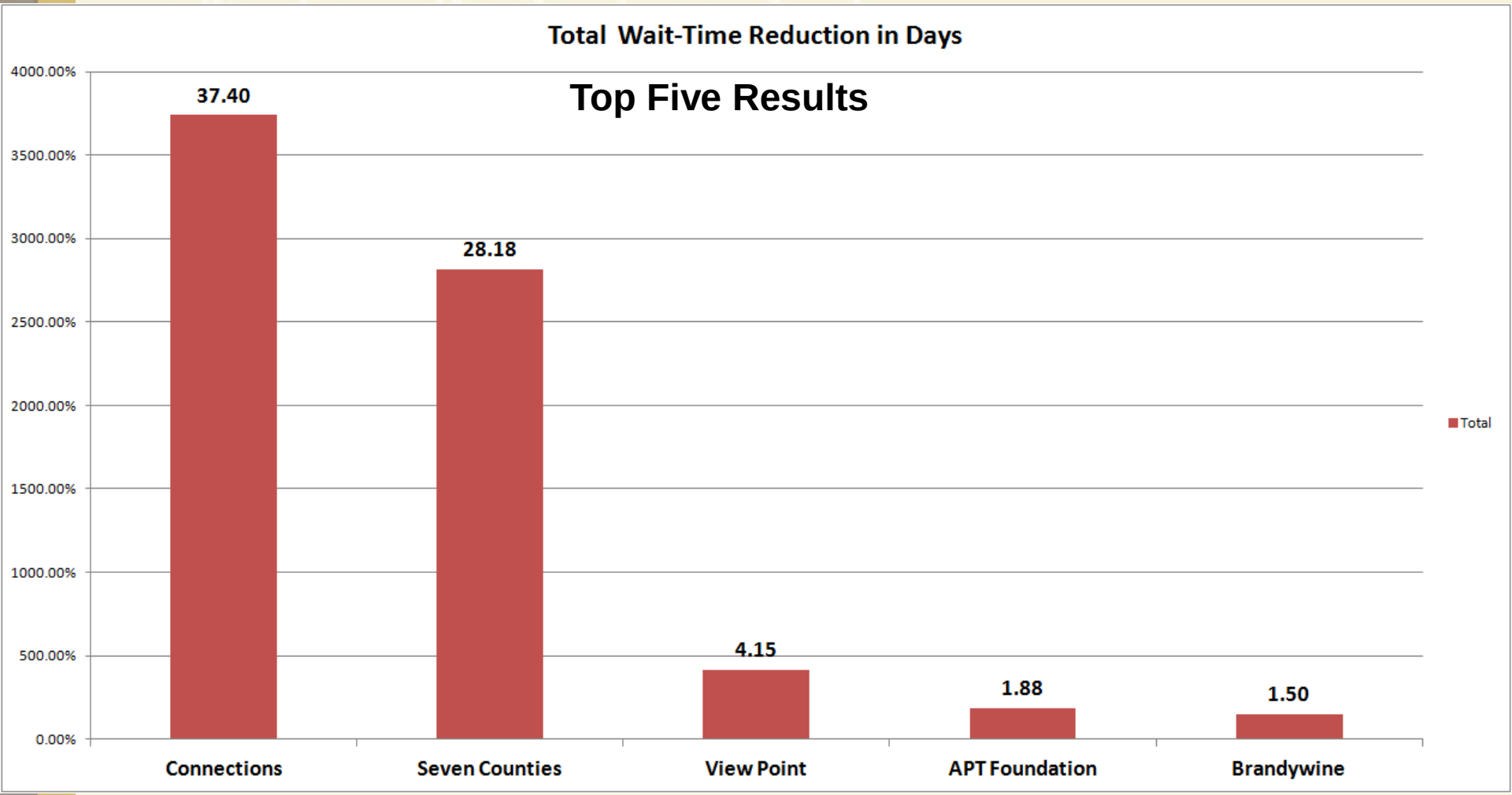
## Access Process - Wait time by Division

Information based upon the initial individualized GAP Analysis Charts



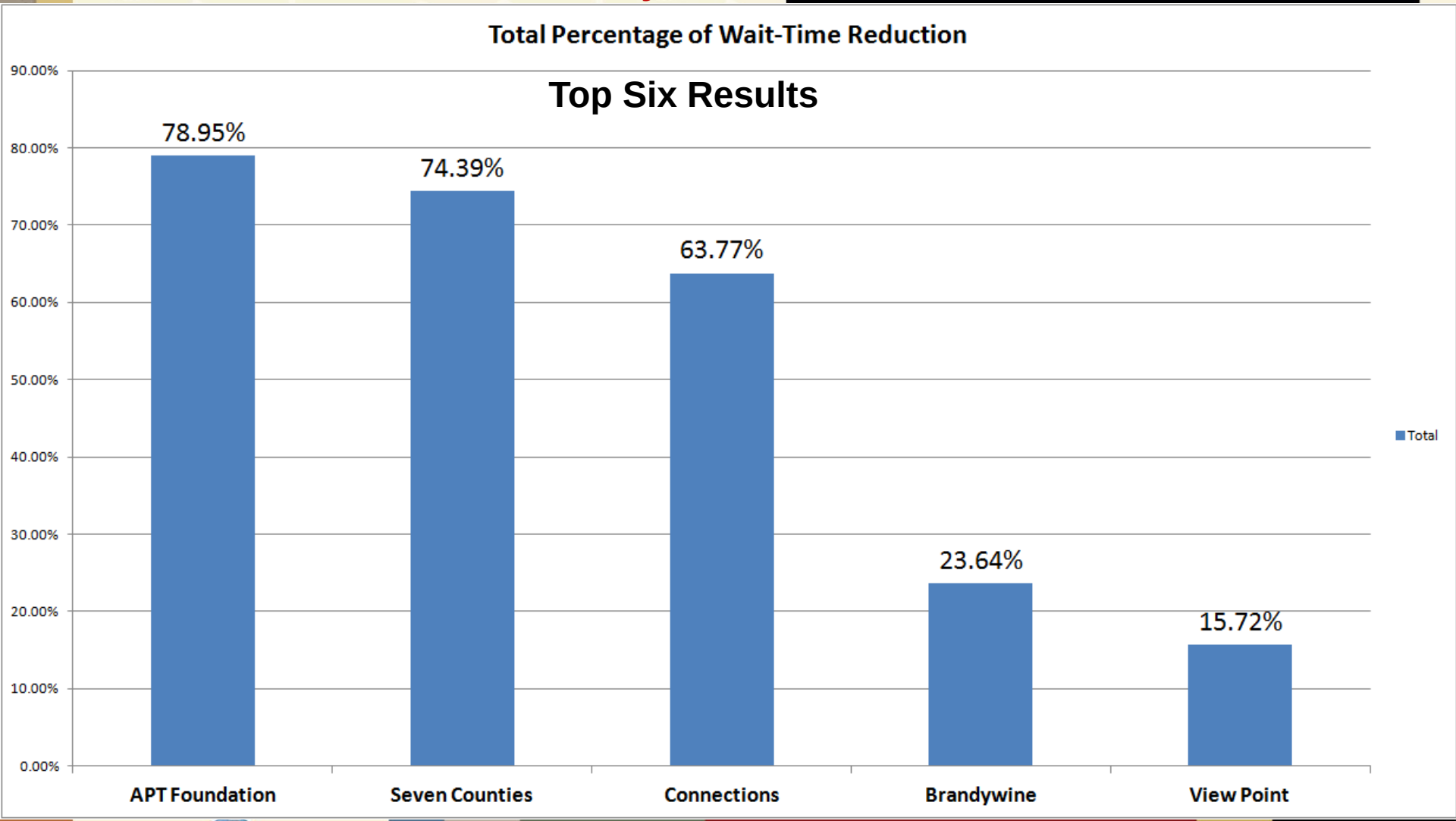
# Access to Treatment Process Flows – Measurement Process Summary





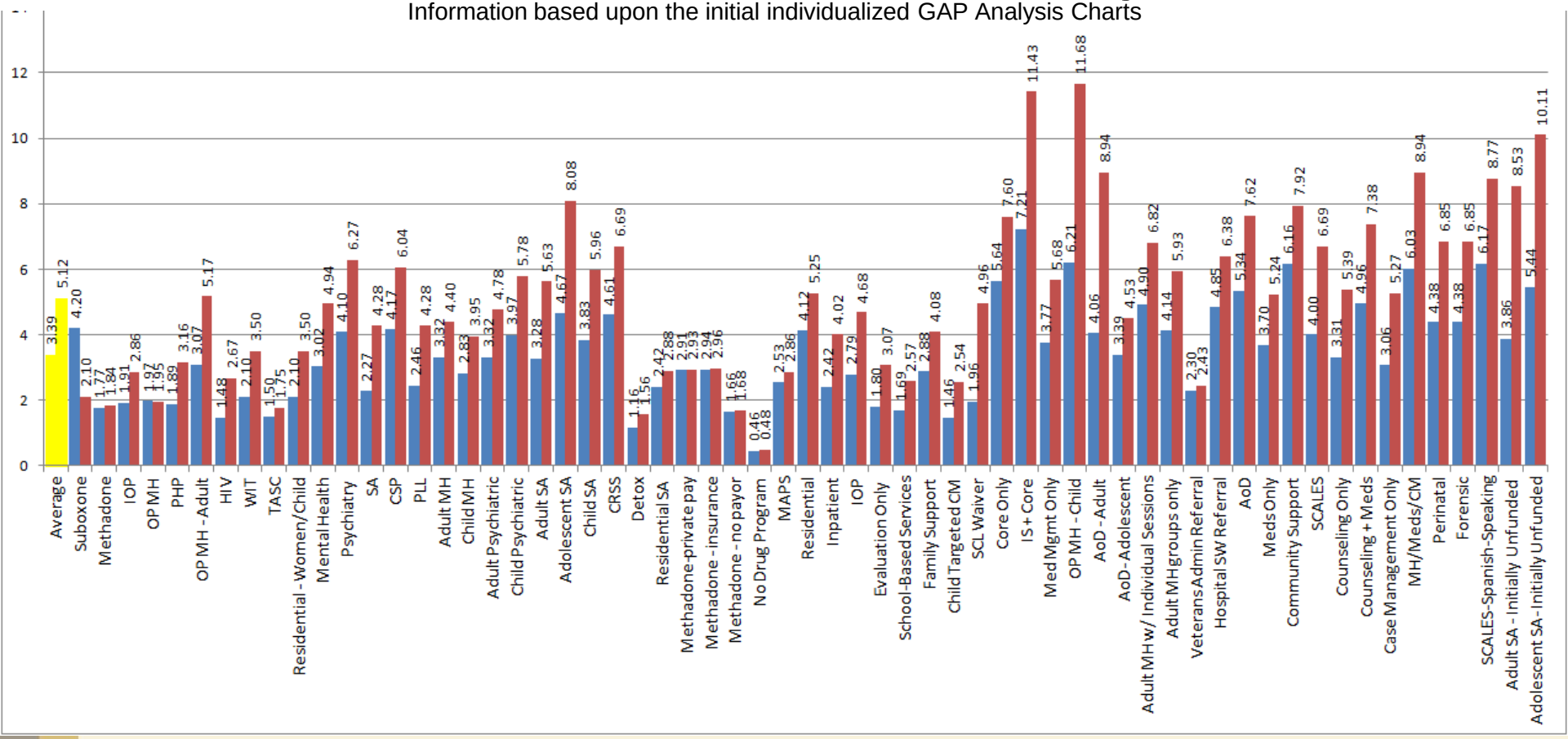
# Access to Treatment Process Flows – Measurement Process Summary





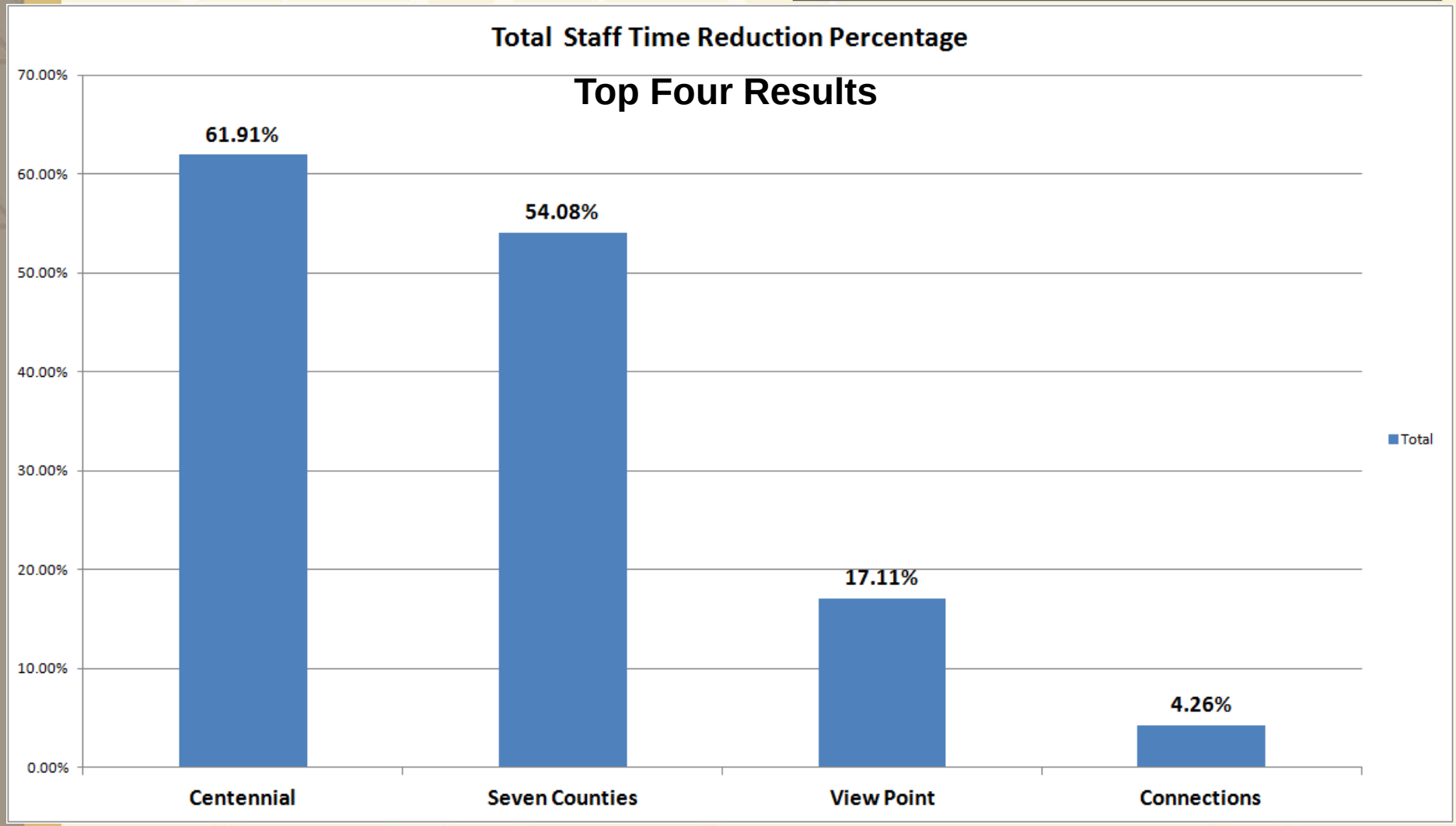
# Access Process - Staff vs. Client time by Division

Information based upon the initial individualized GAP Analysis Charts



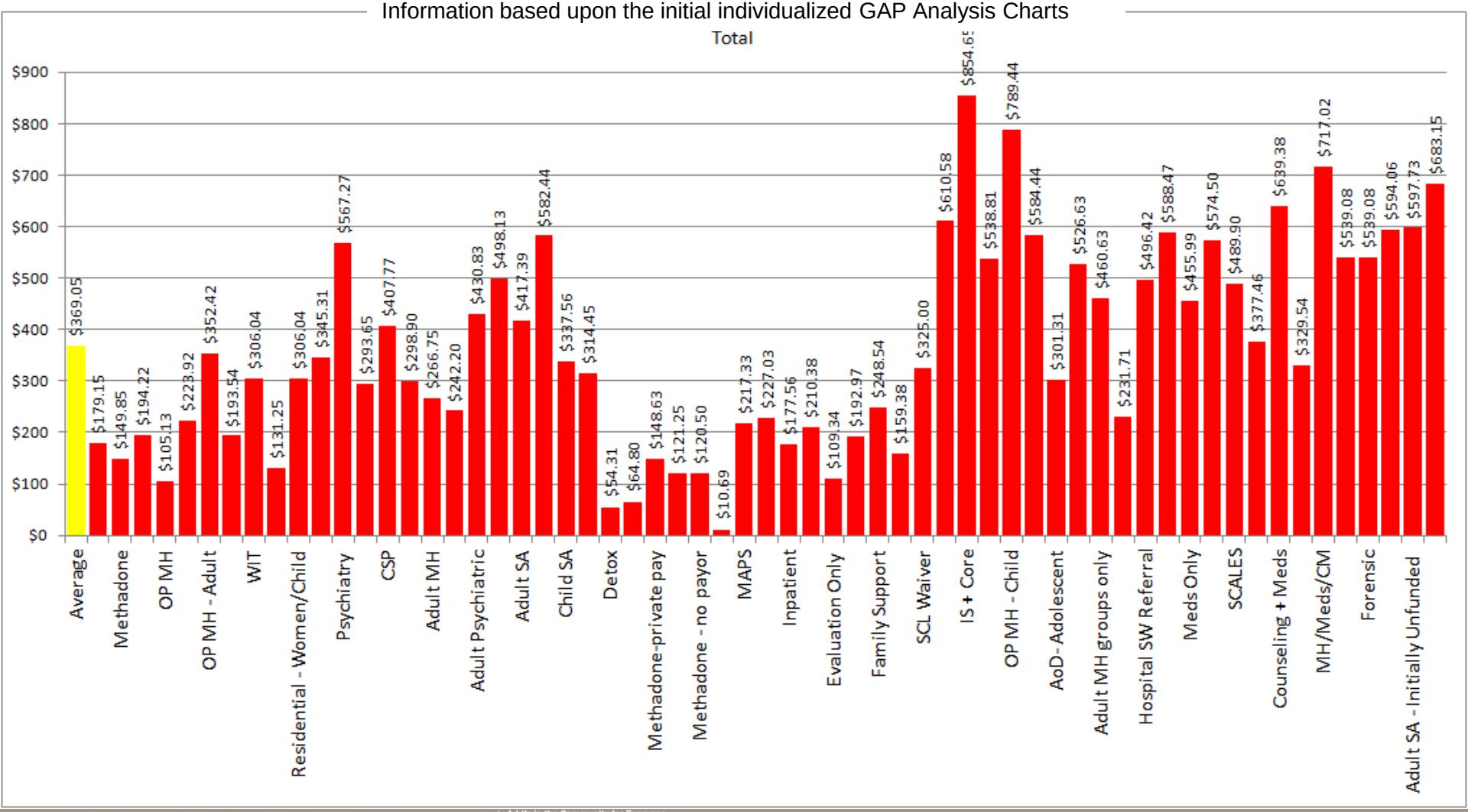
# Access to Treatment Process Flows – Measurement Process Summary



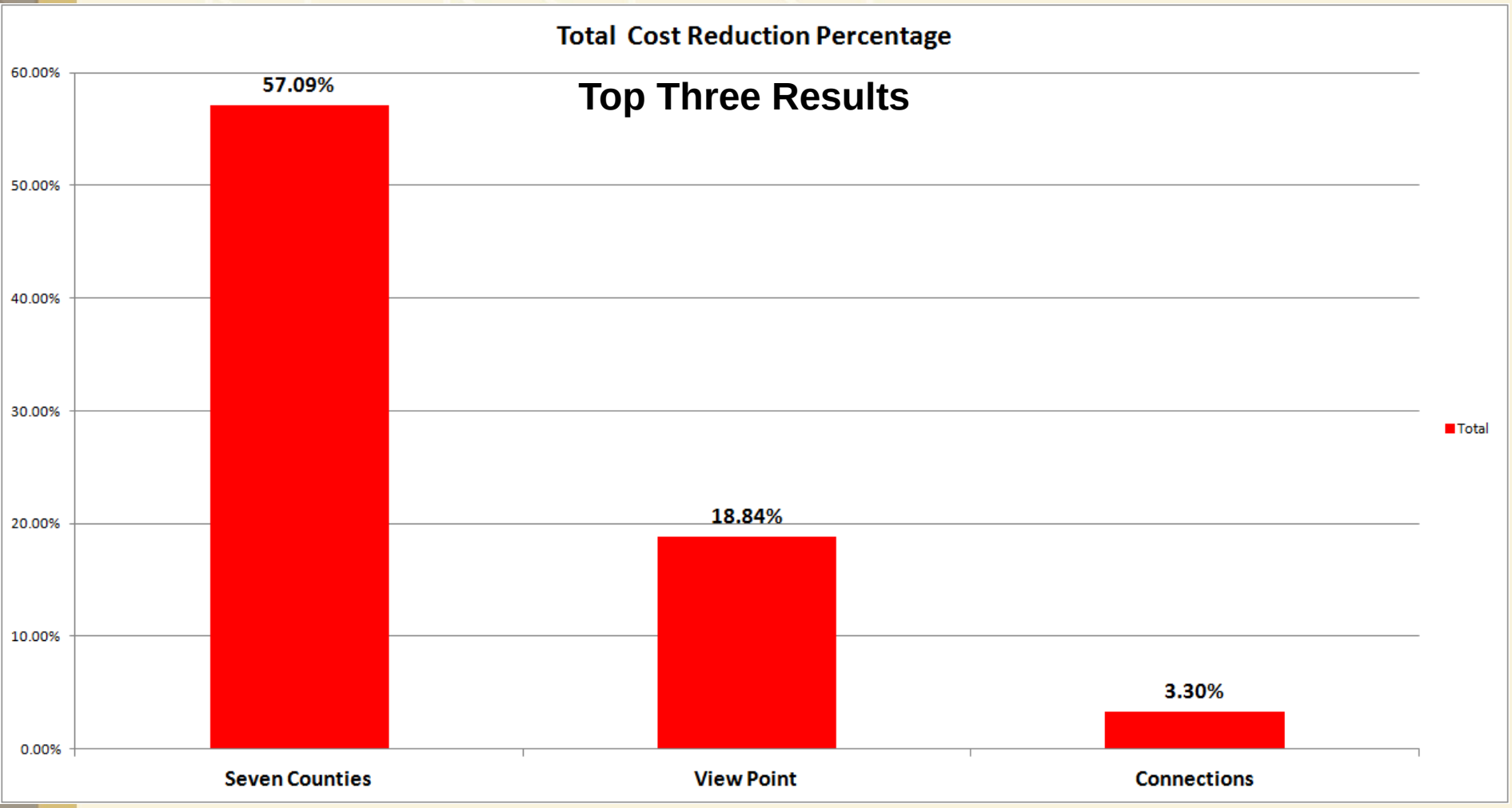


# Access Process – Average Cost by Division

Information based upon the initial individualized GAP Analysis Charts



# Access to Treatment Process Flows – Measurement Process Summary



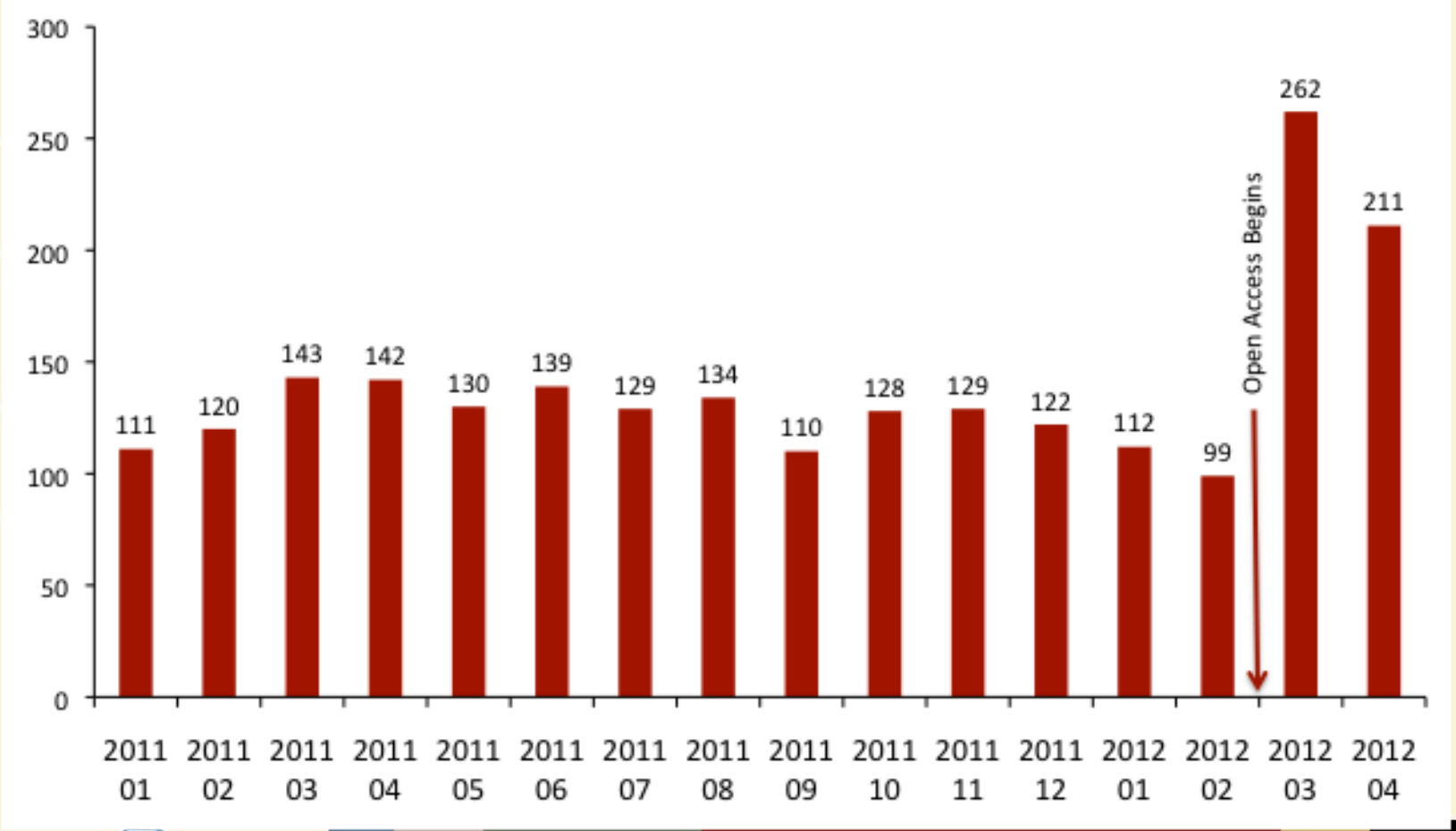
# Annual "Access to Care Cost Efficiency Gains" for Top Two Centers

1. **Seven Counties**:
   Annual Savings = $741,376.25

2. **View Point Health**:
   Annual Savings = $321,729.58

**3. Combined Total Savings: $1,063,105.80**

# Case Study: Journey Mental Health Center, Madison, WI – Same Day/Open Access Initial Assessment Services – Reduced Cost Per Assessment



# Collaborative Documentation Efficiencies Achieved:

**In this Cohort**:

1. Noted by Teams as #2 Top Success Achieved through Learning Collaborative

2. Overall, a 20% reduction in Staff Time was achieved (up to 8 hours of post documentation time savings per staff per week)

3. **Average annual savings of $317,411 per Center**.

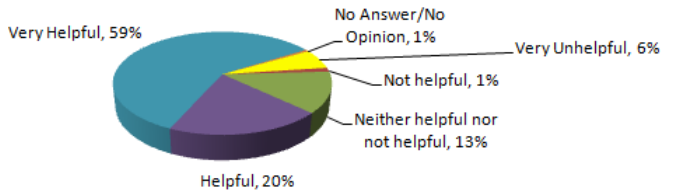
# Consumer Survey Results

**Consortium Grant Results**

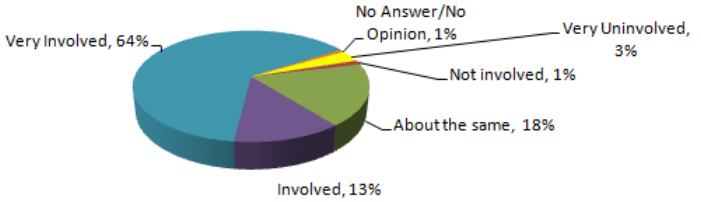
**Collaborative Documentation Survey**

*Thank you for taking a minute to answer a few questions about your session today. We're working on mal*
*tracking the work we do, making sure our notes are accurate, and making s*

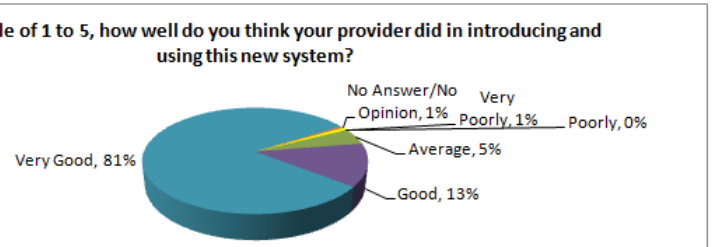
| 1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session? | Percentages Total | Total % | Nat. Avg. | Diff. |
|---|---|---|---|---|
| 1 Very Unhelpful | 30 | 6% | 5% | 1% |
| 2 Not helpful | 6 | 1% | 1% | 0% |
| 3 Neither helpful nor not helpful | 62 | 13% | 9% | 4% |
| 4 Helpful | 95 | 20% | 28% | -9% |
| 5 Very Helpful | 286 | 59% | 53% | 6% |
| NA No Answer/No Opinion | 3 | 1% | 3% | -2% |
| Total/Approval %: | 482 | 93% | 94% | -1% |



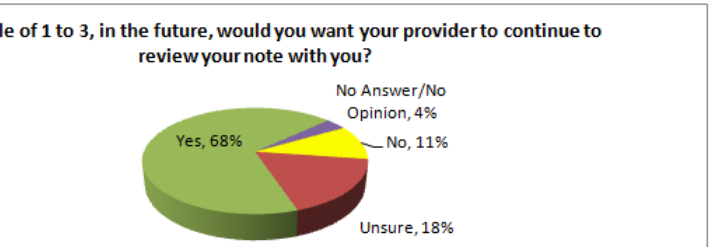

| 2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)? | Total | Total % | Nat. Avg. | Diff. |
|---|---|---|---|---|
| 1 Very Uninvolved | 16 | 3% | 3% | 0% |
| 2 Not involved | 6 | 1% | 1% | 0% |
| 3 About the same | 87 | 18% | 14% | 5% |
| 4 Involved | 61 | 13% | 28% | -16% |
| 5 Very Involved | 308 | 64% | 51% | 13% |
| NA No Answer/No Opinion | 4 | 1% | 3% | -2% |
| Total/Approval %: | 482 | 95% | 96% | 0% |




| 3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system? | Total | Total % | Nat. Avg. | Diff. |
|---|---|---|---|---|
| 1 Very Poorly | 4 | 1% | 1% | 0% |
| 2 Poorly | 0 | 0% | 0% | 0% |
| 3 Average | 24 | 5% | 4% | 1% |
| 4 Good | 63 | 13% | 24% | -11% |
| 5 Very Good | 389 | 81% | 69% | 12% |
| NA No Answer/No Opinion | 3 | 1% | 2% | -2% |
| Total/Approval %: | 483 | 99% | 99% | 0% |




| 4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you? | Total | Total % | Nat. Avg. | Diff. |
|---|---|---|---|---|
| 1 No | 51 | 11% | 6% | 5% |
| 2 Unsure | 85 | 18% | 12% | 6% |
| 3 Yes | 330 | 68% | 77% | -9% |
| NA No Answer/No Opinion | 17 | 4% | 6% | -2% |
| | 0 | 0% | 0% | 0% |
| | 0 | 0% | 0% | 0% |
| Total/Approval %: | 483 | 89% | 94% | -5% |



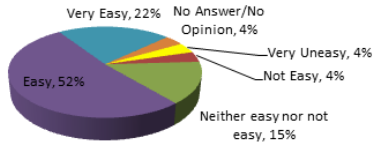
# Staff Survey Results

**Responses for All Participating Centers**

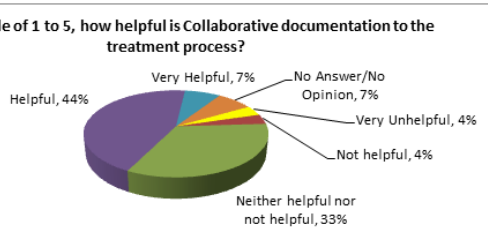
**Collaborative Documentation STAFF Survey**

*Staff, please take a moment and answer the following questions concerning Collaborative Documentation. Your responses will assist in evaluating the process as it relates to not only client care, but employee workplace satisfaction. Thanks! . We value your opinion!*

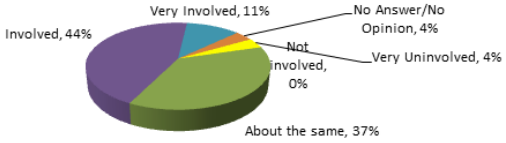
| 2. On a scale of 1 to 5, how easy was it to learn to do Collaborative documentation? | Total | Total % |
|---|---|---|
| 1 Very Uneasy | 1 | 4% |
| 2 Not Easy | 1 | 4% |
| 3 Neither easy nor not easy | 4 | 15% |
| 4 Easy | 14 | 52% |
| 5 Very Easy | 6 | 22% |
| NA No Answer/No Opinion | 1 | 4% |
| Total/Approval %: | 27 | 93% |




| 3. On a scale of 1 to 5, how helpful is Collaborative documentation to the treatment process? | Total | Total % |
|---|---|---|
| 1 Very Unhelpful | 1 | 4% |
| 2 Not helpful | 1 | 4% |
| 3 Neither helpful nor not helpful | 9 | 33% |
| 4 Helpful | 12 | 44% |
| 5 Very Helpful | 2 | 7% |
| NA No Answer/No Opinion | 2 | 7% |
| Total/Approval %: | 27 | 93% |

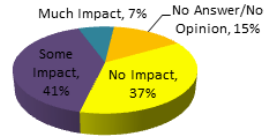



| 4. On a scale of 1 to 5, how involved are your clients in the treatment process as a result of using Collaborative documentation? | Total | Total % |
|---|---|---|
| 1 Very Uninvolved | 1 | 4% |
| 2 Not involved | 0 | 0% |
| 3 About the same | 10 | 37% |
| 4 Involved | 12 | 44% |
| 5 Very Involved | 3 | 11% |
| NA No Answer/No Opinion | 1 | 4% |
| Total/Approval %: | 27 | 96% |




| 5. On a scale of 1 to 5, how helpful has Collaborative documentation been on your paperwork proficiency? | Total | Total % |
|---|---|---|
| 1 Very Unhelpful | 1 | 4% |
| 2 Not helpful | 4 | 15% |
| 3 Neither helpful nor not helpful | 8 | 30% |
| 4 Helpful | 9 | 33% |
| 5 Very Helpful | 3 | 11% |
| NA No Answer/No Opinion | 2 | 7% |
| Total/Approval %: | 27 | 81% |


| 6. On a scale of 1 to 3, has Collaborative documentation had any positive impact on your workplace satisfaction? | Total | Total % |
|---|---|---|
| 1 No Impact | 10 | 37% |
| 2 Some Impact | 11 | 41% |
| 3 Much Impact | 2 | 7% |
| NA No Answer/No Opinion | 4 | 15% |
| Total/Approval %: | 27 | 63% |



# As a result of your participation in this Learning Collaborative, what will you accomplish by next year?

- Top 5 Plans noted by Teams:
  1. Integration with Primary Care or FQHC
  2. Implementation of Collaborative Documentation
  3. Integration of Rapid Cycle Change into CQI process
  4. Open Access, Levels of Care Benefit Design, EHR Advancement
  5. Expansion of Billing Practices including 3rd Party Payers

# Discussion and Q&A

Questions and Comments?

SAMHSA-HRSA
Center for Integrated Health Solutions

# Seven Counties Services

*Tony Zipple, CEO*
*Kelley Gannon, COO*
*Scott Hedges, Sr. VP Medical Svc*
*Marsha Wilson, VP Adult MH*
*David Weathersby, VP Child & Family*
*Diane Hague, VP Addictions*
*Jean Russell, VP Development Svc*

*Laura Fitzgibbons, VP Rural*
*Mary Rose Booker, Dir. Business Svc*
*Susan Rittenhouse, VP Compliance*
*Tish Geftos, Quality Improvement Officer*
*Teresa Wilson, UM Director*
*Don Harris, Dir. Business & Revenue Development*

# Why we decided to join the Learning Collaborative

- *To assist us in improving efficiencies for better service delivery to clients.*
- *To help us prepare for new economic pressures from payer sources.*
- *To focus on improving client outcomes through integrated care and expanding existing co-location projects.*
- *To prepare for implement process for a new electronic health record and accounting software*

# Top Three Accomplishments

- *Productivity Management and Measurement*
- *Open Access*
- *Collaborative Documentation*

# Productivity Management

- *Implemented consistent measurement and management of productivity across the organization*
  - *In 2011, each service unit had its own way to measure productivity… or no measurement at all.*
  - *Built and used standard metrics that were simple, consistent, and easy to understand.*
  - *Raised productivity from 36% to 53%.*

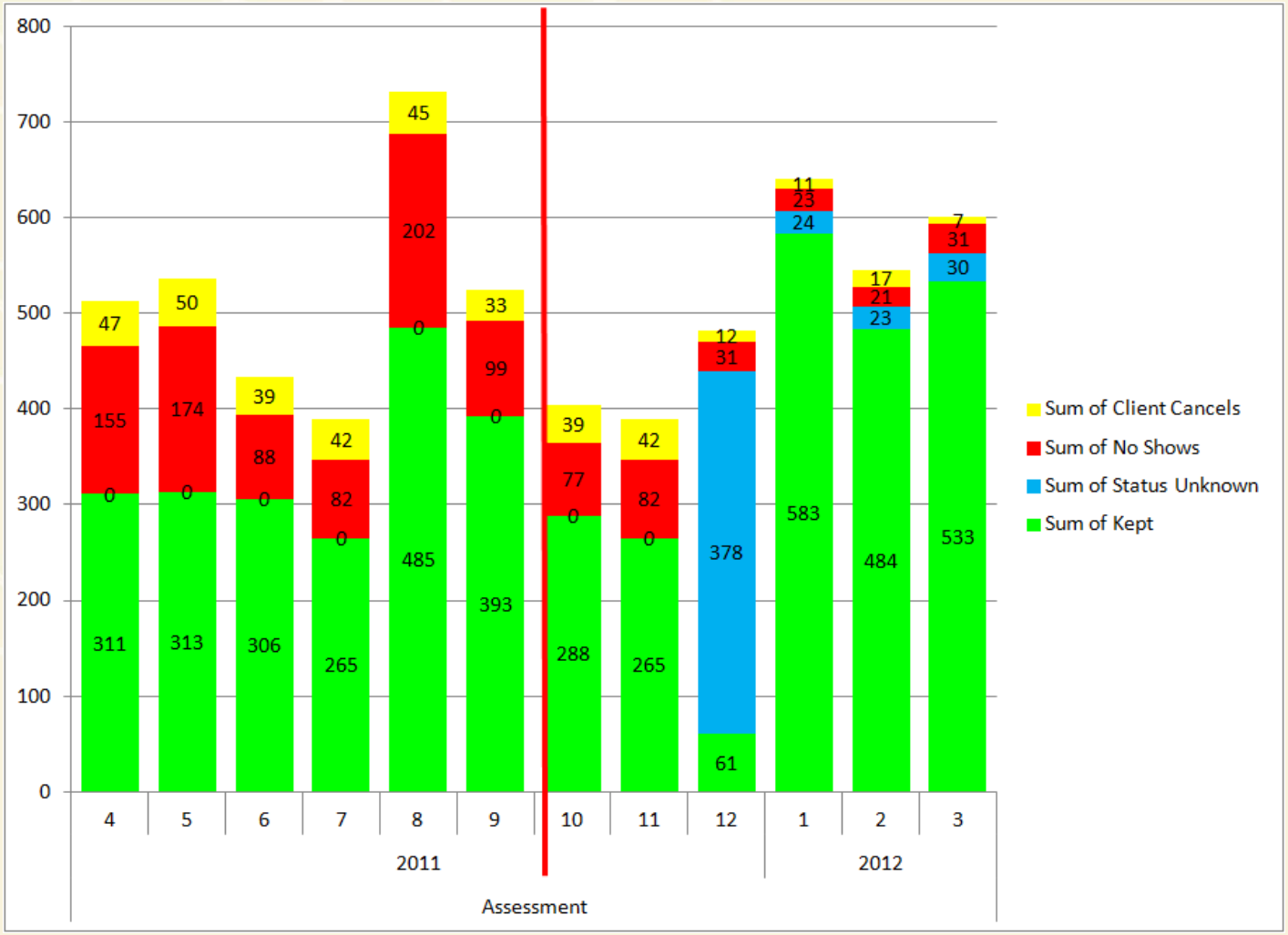
# Open Access

- *Implemented open access across all locations*
  - *Major culture shift required.*
  - *Reduced wait for first appointment from over 15 days to under 5 days.*
  - *Reduced no-show rate from 40% to 11% .*
  - *Needed to adjust intake processes for walk-in client flow.*
  - *Individual service site circumstances are not as “unique” as they thought.*

# Collaborative Documentation

- *Collaborative documentation is now the standard*
  - *Piloted collaborative documentation with 25 clinicians.*
  - *Surveyed clients during pilot – 90% of clients said it was helpful or very helpful for them.*
  - *Clinicians were more enthusiastic with great client feedback.*
  - *Successful clinicians made terrific testimonials.*
  - *It improved productivity **and** quality of care.*

# Results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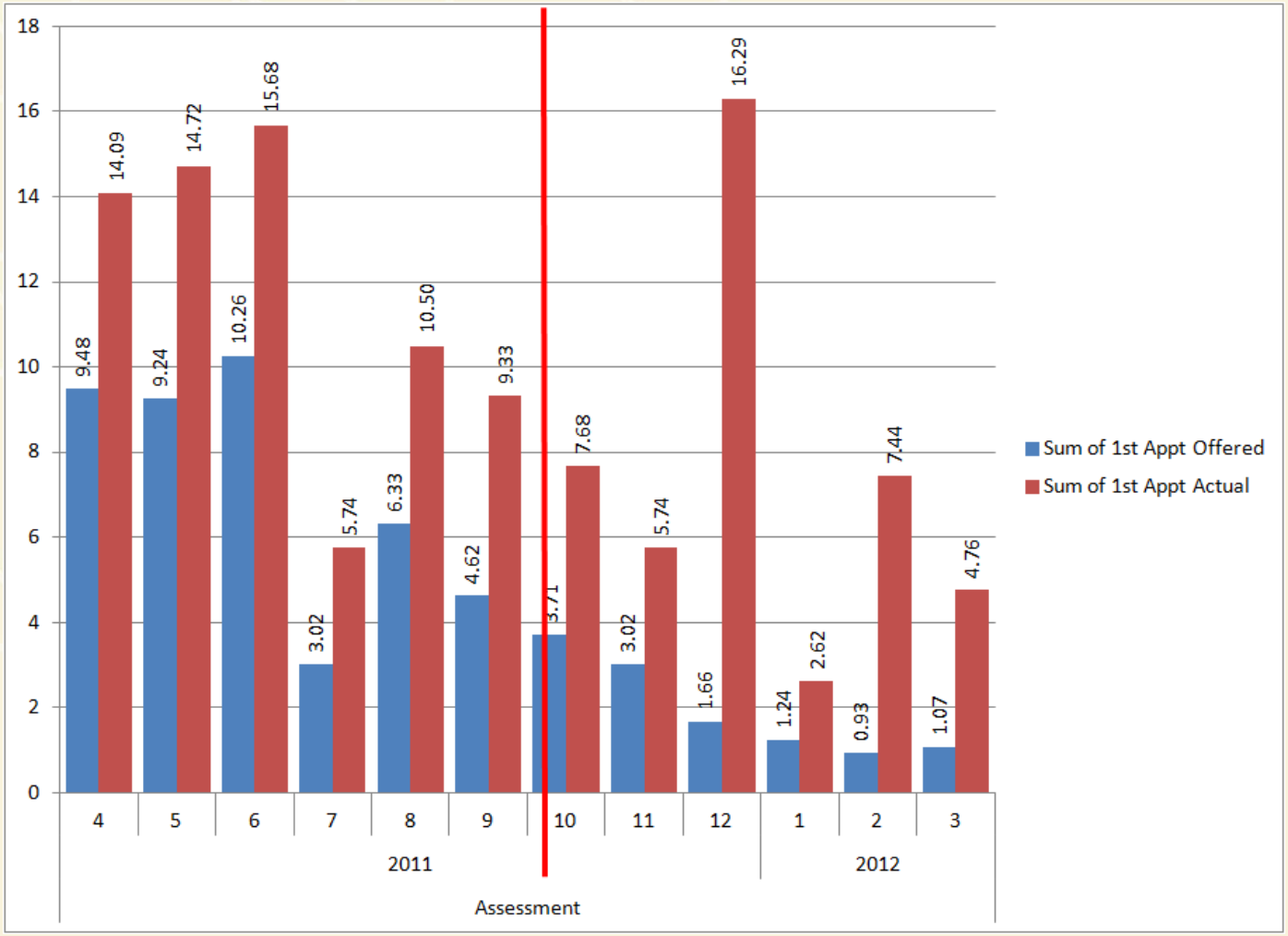
2011
2012
Assessment
Sum of Client Cancels
Sum of No Shows
Sum of Status Unknown
Sum of Kept

# Results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9.33
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3.02
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1.66
16.29
1.24
2.62
0.93
7.44
1.07
4.76
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7
8
9
10
11
12
1
2
3
2011
2012
Assessment
Sum of 1st Appt Offered
Sum of 1st Appt Actual

# Results

| Access Comparison Worksheet | | | | |
|---|---|---|---|---|
| | Total Staff Time (Hrs) | Total Client Time without Wait-time (Hrs) | Cost for Process | Total Wait-time (Days) |
| Old Process Averages: | 3.30 | 2.55 | ($202.27) | 37.88 |
| New Process Averages: | 1.52 | 1.36 | ($86.79) | 9.70 |
| Savings: | 1.79 | 1.19 | $115.48 | 28.18 |
| Change %: | 54% | 47% | 57% | 74% |
| | | Avg. Number of Intakes Per Month | 535 | |
| | | Intake Volume Change %: | 43% | |
| | | Monthly Savings: | $61,781.35 | |
| | | Annual Savings: | $741,376.25 | |

MTM Services


www.mtmservices.org

# What's Next

- *Implementation of EHR and financial software for better tools and measurement*
- *Increase centralized intake and scheduling*
- *Next level gains – move productivity to over 57%, no shows to under 8% and days to first appointment to 3.*
  - *Expect tougher incremental improvements*
- *Position for primary care integration*
  - *Expanded bi-directional colocation*

# SAMHSA-HRSA Center for Integrated Health Solutions

## *View Point Health*

*Frank Berry, CEO*

*Judy Fitzgerald, VP of Strategy*

*Jennifer Hibbard, VP of Programs*

*Yvette Nurse, Director of Outpatient Services*

# Why we decided to join the Learning Collaborative

**View Point Health Vision:**

Building healthy lives and healthy families through high quality comprehensive care.

We recognized we needed expert guidance:

- Transform our culture
- To change our clinical practice
- Address the whole health needs of our clients

# Our Goals

- Integration with Primary Care
- Provide high quality  customer service
- Improved access to services
- Engage clients in treatment from planning to discharge
- Maximize use of clinicians' therapeutic time and improve efficiency
- Improve outcomes for our clients

# Top Four Accomplishments

1. *Open Access at Outpatient Centers*
2. *Implemented Collaborative Documentation*
3. *Centralized Scheduling*
4. *Enhanced Emerging Partnership with FQHC*

# Open Access at Outpatient Centers

- *Lesson learned*
  - *We learned to remain flexible, listen to suggestions from staff, show appreciation and encourage teamwork.*
- *Data*
  - *Increased number of intakes by 14% from Jan 17 – Mar 30*
  - *Estimated Monthly Savings = $32,682*
  - *Estimated Annual Savings = $392,184*
- *Current Barrier*
  - *Streamline intake paperwork to keep appointment within 1 hour*
  - *New EHR implemented March 1, 2012*

# Collaborative Documentation

- *Training and Pilot Project for Collaborative Documentation helped clinicians make the philosophical shift*
- *Improved efficiency*
  - *"Quality Measures": Redesigned productivity system to incentivize outcomes rather than outputs, improve client engagement, a team approach incentivizes all staff to work toward a common mission, documentation quality audit score and incorporate into performance plans.*

# Summary of Client Feedback on Collaborative Documentation :

- How helpful was it to you to have your provider review your note with you at the end of the session?

  82% “Helpful or Very Helpful”
- How involved did you feel in your care, compared to past experiences? 96% “Involved or Very Involved”
- How well do you think your provider did in introducing an using this new system? 96% “Good or Very Good”
- Would you want your provider to continue to review your note with you? 86% “Yes, Unsure”

# Centralized Scheduling

- *No-Show management*
- *Hired 2 Engagement Specialists*
- *Lesson learned*
  - *Need to add more phone lines and staff to Access call center to support centralized scheduling*
- *We need to analyze no-show data trends*

# What's Next

1. *Open Access & Clinical Pathways for other programs*
2. *Identified measurable outcomes and targets*
3. *Integration with Primary Care Goals:*
   - *Open Medical Suite within Outpatient Center*
   - *Bridge/Link Electronic Health Records*
   - *Make it a seamless process for the client*
     - *All clerical staff can schedule for both Primary Care and Behavioral Health*
     - *Streamline Intake Process*

# Questions

www.integration.samhsa.gov